

Care Quality Commission

Inspection Evidence Table

St Johns Medical Centre (1-10006311414)

Inspection date: 10 January 2023

Date of data download: 13 January 2023

Overall rating: Good

Safe

Rating: Good

At the last inspection on 16 August 2022 we rated the practice as requires improvement for providing safe services because the systems, processes and safety records to keep people safe were inconsistent. At this inspection we found that those areas had been improved upon. Improved systems had been implemented and were now embedded throughout the practice.

Recruitment systems	Y/N/Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">At the previous inspection we found that although clinical staff had been checked to ensure they were up to date with Hepatitis B immunisations, there was no system in place to ensure that all staff who had direct contact with patients, including reception staff, were up to date with all routine immunisations. Immediately following the inspection the practice told us that all staff had now received communication through formal auditable channels about vaccination history in line with UK Health Security Agency (UKHSA) guidance and responses were being collated. Any staff not being able to submit data would be supported to ensure the information was available. A new system was in place for new starters who would be subjected to the same screening process.At this inspection we saw evidence that the above had been implemented and embedded. All staff had been sent a letter asking them to confirm their immunisation status for all infectious diseases and their details had been uploaded to the practice's internal document system where information could be viewed at a glance and updated whenever necessary. New starters would be asked for the information at the beginning of their term of employment. We saw that a failsafe system was in place.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 16 August 2022	Yes

Explanation of any answers and additional evidence:

- At the previous inspection in August 2022 there was no system to ensure that clinicians' personal equipment, such as sphygmomanometers were included in the process of calibration.
- At this inspection we saw a system in place whereby all clinicians were asked for details of their personal equipment. The details were then uploaded to the practice's internal document system where information could be viewed at a glance and updated whenever necessary. We saw that all personal equipment would be included in any further testing along with the practice's already embedded system to check and calibrate equipment.

Information to deliver safe care and treatment

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> • At the previous inspection we were told that non-medical prescribers did so within their competencies as per their individual prescribing formularies and professional training but there was no formalised system in place to check this. Although there was a clear open door policy for staff to seek clarification when they were unsure of something, as well as annual appraisals, there was no regular pro-active ad-hoc monitoring or review of consultations to ensure that errors were prevented before they happened. • Following the inspection the practice told us a new supervision policy was implemented which included non-medical prescribers. Partners were allocated individuals for whom they were responsible and had to undertake a quarterly review of the individual as well as supplementary ad-hoc reviews. The reviews were to be recorded and documented for evidence. Monitoring of prescribing and consultations were to take place against the individual's prescribing formulary to ensure they were not working or prescribing outside of their competencies. The practice submitted a copy of the new policy in evidence. • At this inspection we saw that this process had been implemented and the policy was being followed. We were told of examples where clinical cases and prescribing competencies had been discussed. We were told that this process would be continued going forward and was a positive enhancement to the already embedded informal discussions that took place. We saw an audit of medicine prescribing of nurse practitioners that had been checked against their formularies to assure competencies were upheld. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Whilst discussing significant incidents with the partners at the previous inspection we identified that deaths were not routinely reviewed. We also identified that incidents were being documented after they had been raised, discussed and investigated rather than pro-actively and when they occurred. Immediately following the inspection we were told that deaths were reviewed at the practice as the partners were advised of deaths and a spreadsheet was kept centrally at the practice. However, to supplement and improve the process, the practice had commenced a system where each unexpected death automatically generated a significant event and each death would be reviewed by a partner to ensure there was no indication of unsafe care or learning required. • At this inspection we saw that this system was effective and were shown an unexpected death at hospital that had been raised as a significant event. This was being reviewed and discussed to see if anything could have been done differently. In addition, it had identified that some patients may require additional checking to ensure they were safe and warm at home, specifically during winter pressures. • It was evidence from this inspection that the practice learned and made improvements when discrepancies were identified or when things went wrong. The practice accepted the improvements identified at the previous inspection and quickly implemented fixes or new processes to ensure that safety within all areas of the safe key question were optimised. 	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • At the previous inspection whilst we saw examples of good practice for the dissemination of information such as a Whatsapp group for all clinicians where new guidance was shared, there was no formal process for the dissemination and review of safety alerts and no one person within the practice responsible for receiving and passing on safety alerts which was left to chance. There was no formal documented approach that could evidence alerts received into the practice, disseminated for action, action having been taken, or review having taken place. • Since the inspection we were told by the practice that the dissemination of safety alerts was now being done through the practice's internal document system ensuring a receipt was logged by all employees who received it and any non compliance of acknowledgement would be chased. • At this inspection we were told who the nominated persons were to ensure that safety alerts were formally reviewed and passed on to appropriate staff to deal with them. 	

- We saw several examples where action had been taken on the back of safety alerts and patient safety had been increased. For example as a result of a safety alert where potential issues may occur after switching brands of medicine, all patients who had been switched to another brand had been contacted to make sure they understood why this had been done and to discuss any contraindications that might be caused.

